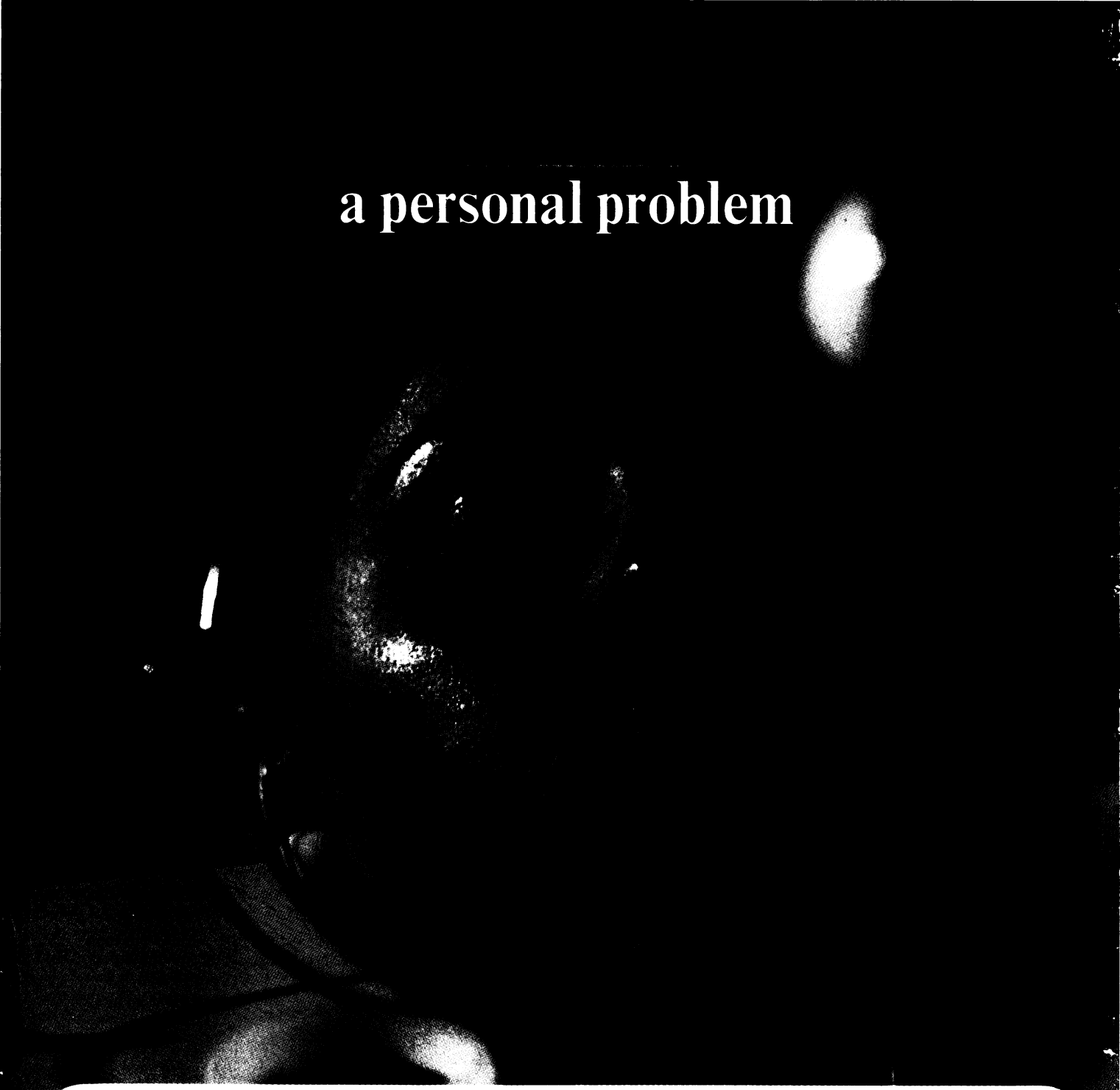

Neo-Medrol Acne Lotion

the professional solution

now available in new 100 ml economy size

To the teenager, acne is a very personal problem. At a time when a young person most desires popularity and social acceptance, skin blemishes often undermine self-confidence and may cause psychic as well as physical scars.

Neo-Medrol Acne Lotion offers a professional solution to the problem of acne. Four active ingredients control inflammation, reduce excessive oiliness, and promote healing. Neo-Medrol Acne Lotion spreads easily over the affected area and works invisibly. The lotion's non-medicated scent and non-greasy, vanishing lotion base make it highly acceptable to both boys and girls. Neo-Medrol Acne Lotion is available in convenient plastic squeeze bottles. The choice of sizes helps ensure economical treatment.

Each ml contains Medrol (methylprednisolone) acetate 2.5 mg (0.25%), neomycin sulphate 2.5 mg (0.25%) (equivalent to 1.75 mg neomycin base), sulphur (from colloidal sulphur) 50 mg (5.0%), and aluminium chlorhydroxide complex 100 mg (10.0%).

Administration: Apply sparingly to the affected area once or twice a day. Most patients find the once-a-day application sufficient.

Cautions: Should not be used in the presence of cutaneous infections due to organisms for which specific therapy is not available. Avoid contact with the eyes. Detailed information is available on request.

Supplied: 30 ml, 60 ml, and 100 ml plastic squeeze bottles.

Also available without neomycin as Medrol Acne Lotion in 30 ml, 60 ml and 100 ml plastic squeeze bottles.

745 REGISTERED TRADEMARKS: MEDROL, NEO-MEDROL CE 7568.2

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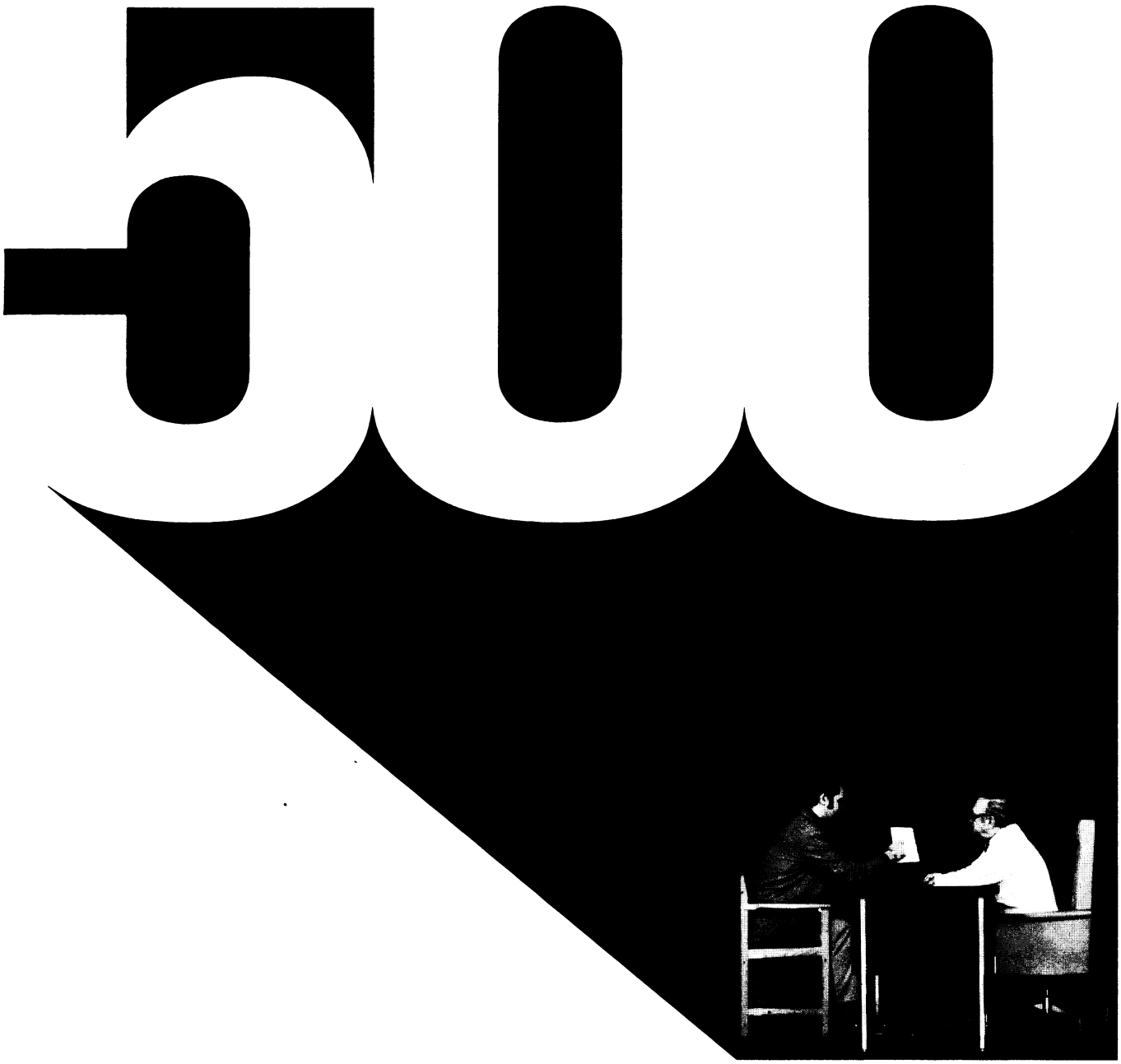
Upjohn

How a ROCOM consultant can help you save up to 500 hours per year and improve patient care by the problem-oriented approach to managing medical time.



The ROCOM system can stretch a medical hour to 80 minutes, make practice and patient care more productive.

At left is one of 27 time management consultants of ROCOM who can assist physicians to adapt this new widely acclaimed "Problem-Oriented Medical Record" system to everyday practice.

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- Assist aides in implementation.
- Suggest the necessary Medical Record, Health History, and Telephone message forms to provide better communication within the health care team.
- Help to enhance patient scheduling and flow.
- Help you save up to 500 hours per year of medical time.

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Some heads don't need Selsun*

. . . But, for controlling dandruff, there isn't a more effective treatment than

Selsun*

Selenium Sulfide Suspension
ABBOTT STANDARD

A non-alkaline lathering suspension
Controlled pH

EFFICACY: In a recent clinical study[1], 2.5% Selenium Sulfide (SELSUN) was compared with 2% zinc pyrithione. SELSUN was found to be more effective.

- **Improvement noted earlier, after the second treatment.**
- **Suppression of scaling generally faster by 3 weeks.**

SAFETY: No significant selenium absorption has been observed.
It is precisely because of its safety and efficacy record for almost two and a half decades that medicinal SELSUN has come to be regarded as "Classic Therapy" for dandruff and seborrheic dermatitis.

Precautions and side effects: Keep out of the eyes: burning or irritation may result. Avoid application to inflamed scalp or open lesions. Occasional sensitization may occur.

1. Kligman, A.M., et al.: J. Soc. Cosmet. Chem., 25:73, 1974.

PHARMACEUTICAL PRODUCTS DIVISION
ABBOTT LABORATORIES, LIMITED
MONTREAL, CANADA

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*RD. T.M. 402469

selsun*

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dandruff treatment

Medically approved

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Amoxil*

(amoxicillin)

Pediatric Suspensions in 2 potencies— in convenient 5 & 7 day therapy units—and NEW Pediatric Drops.

AMOXIL drops and suspensions were developed specifically for easy and convenient use in pediatric practice.

AMOXIL's pleasant fruit flavor makes it easy to administer.

AMOXIL is almost completely absorbed so there's a lower incidence of gastrointestinal disturbances, particularly diarrhea.

AMOXIL features convenient t.i.d. dosage.

Best of all, AMOXIL possesses all the safety features normally associated with the penicillins.

New AMOXIL Pediatric Drops:	15 ml (50 mg/ml)
AMOXIL-125 Pediatric Suspension:	75 ml (125 mg per 5 ml)—5 day therapy 100 ml (125 mg per 5 ml)—7 day therapy
AMOXIL-250 Pediatric Suspension:	75 ml (250 mg per 5 ml)—5 day therapy 100 ml (250 mg per 5 ml)—7 day therapy

INDICATIONS Infections of the ear, [illegible] upper respiratory tract due to H. influenzae, infections of [illegible] soft tissues due to streptococci, pneumococci, penicillin-sensitive staphylococci; infections of the [illegible] and S. faecalis; infections of the skin and

CHILDREN'S DOSAGE 25 mg/kg/day [illegible] 50 mg/kg/day in divided doses every 8 hours [illegible] staphylococci and H. influenzae. 50 [illegible] streptococci, pneumococci, penicillin-sensitive staphylococci and H. influenzae.

CONTRAINDICATIONS In patients [illegible]

PRODUCT MONOGRAPH AVAILABLE ON REQUEST

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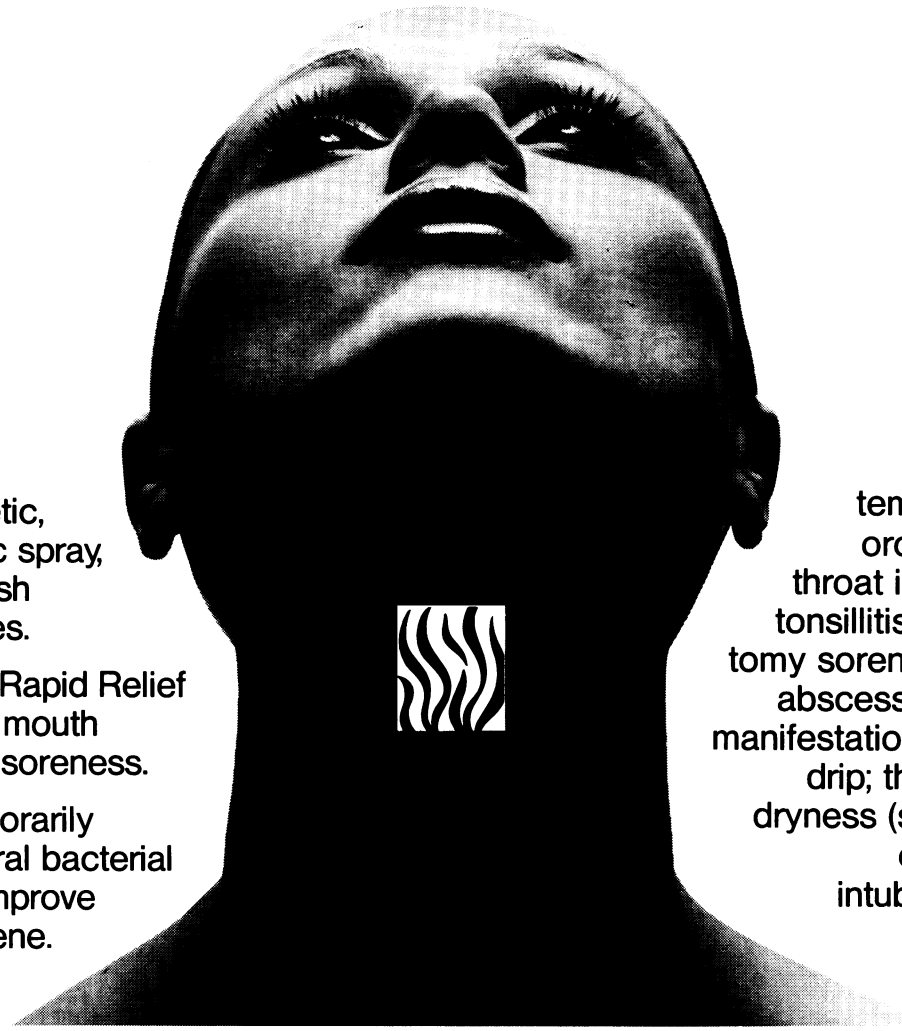
AYERST LABORATORIES
Division of Ayerst, McKenna & Harrison, Limited, Montreal, Canada.
AMOXIL made in Canada by arrangement with BEECHAM, INC.

Ayerst Quality has no substitute

*Reg'd

Sore Throat? Chloraseptic®!

spray, mouthwash, lozenges



- Anaesthetic, Antiseptic spray, mouthwash & lozenges.
- Provides Rapid Relief of throat, mouth and gum soreness.
- Will temporarily reduce oral bacterial flora to improve oral hygiene.

- Prompt, temporary relief of: oropharyngitis and throat infections; acute tonsillitis; post tonsillectomy soreness; peritonsilar abscess; oropharyngeal manifestations of post nasal drip; throat and mouth dryness (smoker's cough, etc.); and before intubation (anti-gag) and after for soreness.

Chloraseptic Prescribing Information

Action: Provides rapid surface anaesthesia.

Description: Available as a green, clear, anaesthetic, antiseptic, deodorising mouthwash and gargle containing phenol and sodium phenolate (total phenol 1.4%), sodium borate, (0.465% w/v). Also available as green hard candy lozenge containing phenol and sodium phenolate, (total phenol 32.5 mg).

Indications: All those conditions where rapid oral surface anaesthesia is required. Will provide rapid symptomatic relief for mouth and throat soreness; oropharyngitis and throat infections, acute tonsillitis; post-tonsillectomy soreness; peritonsillar abcess; oropharyngeal manifestations of postnasal drip; throat and mouth dryness; before intubation (anti-gag) and after (for soreness).

Dosage: As a mouthwash, gargle and spray, use full strength, expel remainder. Repeat every 2 hours as necessary. Lozenges, dissolve one in the mouth every 2 hours up to a maximum of 8 per day.

Precautions: Not recommended for children under 3 years of age.

Supplied: 170 ml with sprayer; 340 ml refill without sprayer; Lozenges in box of 18.

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Division of Norwich Pharmacal Company Ltd.
Paris, Ontario

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Please send me a professional sample of Chloraseptic.

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Signature _____

ECA-62005-7506

NEW

Instant therapy for the topical treatment of both tinea and candidiasis

dermatophytoses*

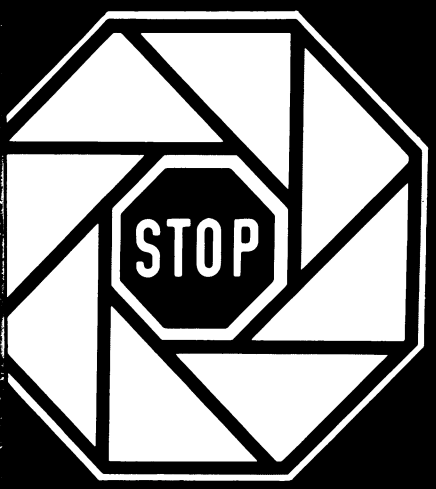
candidiasis

tinea versicolor

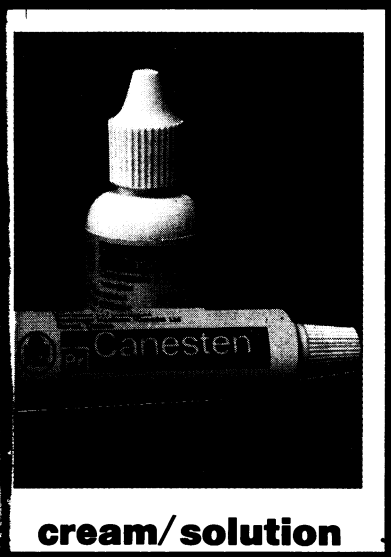
clears the affected area quickly . . .

relieves pruritus usually within the first week

*tinea pedis, tinea cruris, tinea corporis due to susceptible organisms



Dermatophytes
tinea pedis
tinea cruris
tinea corporis
Yeasts
candidiasis
Other Fungi
tinea versicolor



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Instant therapy
when your patient can't wait for time-consuming culture identification

- fungicidal action
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- single - synthetic - entity: not a combination or antifungal antibiotic
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1 LETTERS

An Open Letter To This Month's Guest Editorialist

Dear Dr. Cohen:

Thank you for writing this month's editorial (p. 7) on behalf of women patients. Now I'd like to apply what you say to the medical profession itself. How can physicians expect to treat their female patients without condescension when they don't even do that for their women colleagues? I'm sure you've experienced the kind of thing I mean — the meetings which are constantly addressed by the term "gentlemen", even though some of the participants may not be of that persuasion, or the phrases like "if we are to continue attracting good men into the profession" . . .

As an editor, I don't expect people to sprinkle their prose with unwieldy 'he/shes' or 'him/hers' at every turn, providing there's some acknowledgement at the outset that in fact half the human race happens to be female. But all too often I'm faced with phrases like "this patient should be referred to a good ENT man'. What's so difficult about using the word 'person' — or better still, 'physician'?

Recently I attended a meeting at which many of the participants were Dalhousie University graduates. Dalhousie is well known for having a large proportion of women in its medical school, so I hoped to see and hear fewer instances of this condescension. 'Fraid not — all the male platform speakers were introduced according to their professional capabilities, but the two women who presented cases were referred to as "our local beauties". Now what difference would it have made if they'd had faces like the back end of a bus? They weren't there as contestants in the Miss Canada pageant but as respected physicians of the community. Of course, I ought to acknowledge that when I first attended the same meeting five years ago, the only women on the platform were patients, so things *have* improved.

But it still bugs me when I sit at the same table as a chairman who insists on addressing those present as "gentlemen", even though there are two women physicians in the room besides yours truly. In speaking to two young women who have set up practice in partnership, I found they had similar beefs. One of them is married and one is single, but it seems that at first, neither of them could win with their colleagues, who thought that the unmarried one would leave to get married, and the married one would be constantly going home to look after the children. Two years later, they're still in practice together and show every sign of continuing that way.

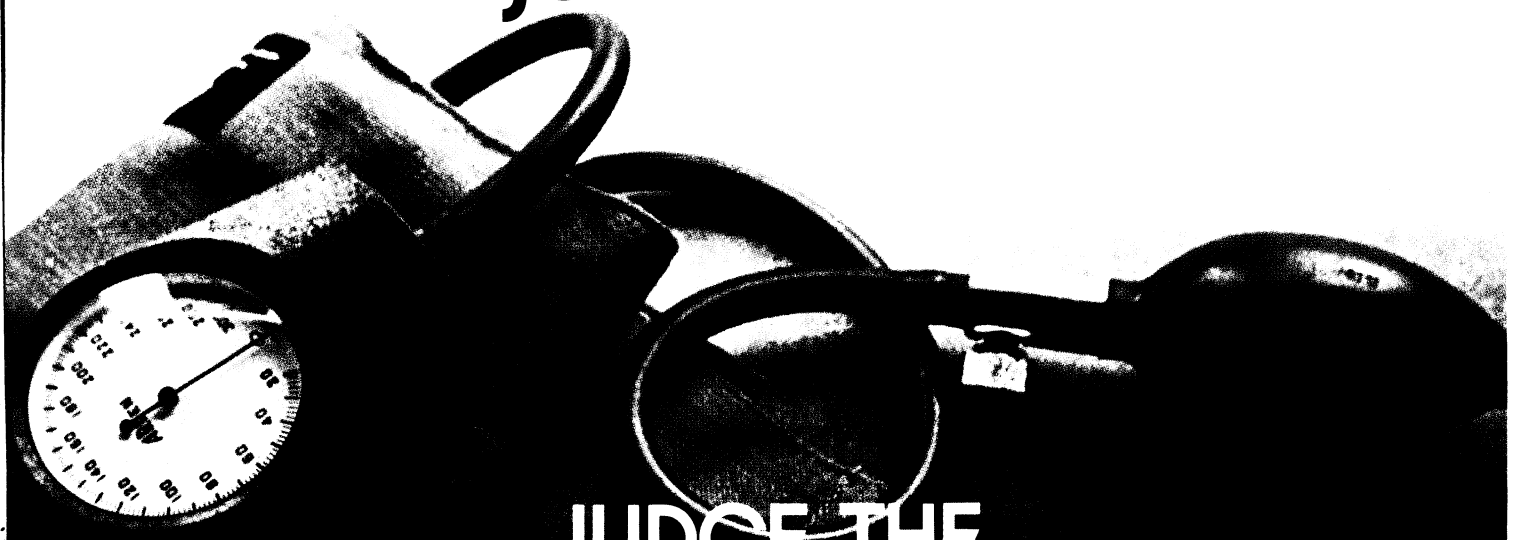
I don't know how it was when you went through medical school, but I've heard instances of admissions committee reports containing comments like: "Aggressive, knowledgeable — will do well" for a male candidate, yet for a female candidate the same report will read: "Very aggressive, but nevertheless should do well". Sauce for the goose?

When the current Ontario Minister of Labor, Dr. Bette Stephenson, became the first woman president of the Ontario Medical Association, one of her (male) colleagues was heard to remark: "Bette'll be all right. She thinks like a man." Perhaps we should reclassify thought processes — masculine and feminine instead of objective and subjective, rather like asking someone if they dream in color.

In case anyone's wondering, I'm not a man hater. Some of my best friends are men, and no, I wouldn't mind if my daughter married one. I'd even let them come and live next door to me. I just don't want to be addressed as one, that's all.

Margaret McCaffery
Editor,
CANADIAN FAMILY PHYSICIAN.

WHEN SUSTAINED ESSENTIAL HIGH BLOOD PRESSURE IS YOUR JUDGEMENT



JUDGE THE ADVANTAGES OF

(methyldopa and chlorothiazide)

EFFECTIVENESS

of two proven agents for lowering supine and standing blood pressure.

PROTECTION

of the vital organs from pressure-related damage.

SIMPLICITY OF DOSAGE

unlike some other antihypertensives requiring complex dosage titration, dosage of SUPRES* is easily established.

SUITABILITY

for a wide variety of hypertensive patients; does not exclude those with chronic respiratory disease or congestive heart failure.

SUPRES*

(methyldopa and chlorothiazide)

INDICATIONS

Essential hypertension.

DOSAGE SUMMARY

Therapy is usually begun by administering one tablet SUPRES*-150 or SUPRES*-250 twice daily during the first 48 hours. Thereafter, daily dosage may be adjusted by deletion of one or addition of one or two tablets, preferably at intervals of not less than two days, until an adequate response has been achieved. The maximal recommended daily dose is 3.0 g of methyldopa and 1.0 to 2.0 g of chlorothiazide (12 tablets of SUPRES*-150 or 8 tablets of SUPRES*-250, respectively). Where maximum dose has provided inadequate blood pressure control, it is suggested that additional methyldopa be given as the single drug to obtain the maximal blood pressure response.

Patients with impaired kidney function may respond to smaller doses of the drug than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those patients with advanced arteriosclerotic vascular disease; this may be avoided by lower doses of SUPRES*.

When increasing dosage, it may be desirable to start with the evening dose to minimize the sedative effect (which sometimes occurs early in treatment or when dose is increased) without exaggerating morning postural hypotension.

Tolerance to SUPRES* may occur occasionally either early or late in treatment, but is more likely between the second and third month after initiating therapy. Increasing the dosage of SUPRES* or either component independently frequently will restore effective blood pressure control.

Transfer from other Antihypertensive Agents

SUPRES* may be introduced into the antihypertensive regimen of patients on treatment with thiazides by stopping the thiazides. In patients on ganglion-blocking agents or guanethidine, by initially decreasing their dosage by fifty percent and subsequently gradually withdrawing these agents while gradually adding SUPRES*, a smooth transition with optimal control of blood pressure can be achieved. Therapy with SUPRES* may be initiated in most other patients already on treatment with other antihypertensive agents (reserpine, hydralazine or MAOI) by terminating these antihypertensive medications. Following such previous antihypertensive therapy, SUPRES*-150 or SUPRES*-250 should be limited to an initial dose of one tablet daily and increased as required at intervals of not less than 2 days.

CONTRAINDICATIONS

Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity to chlorothiazide or methyldopa; pheochromocytoma; unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy alone; anuria; in pregnancy and nursing mothers (see WARNINGS). Use cautiously if there is a history of liver disease or dysfunction.

WARNINGS

Since thiazides cross the placental barrier and appear in cord blood the usage of SUPRES* when pregnancy is present or suspected requires that the benefits of the drug be weighed against its possible hazards to the fetus, including fetal or neonatal jaundice, thrombocytopenia and other adverse reactions that have occurred in the adult. As thiazides appear in breast milk, do not use during lactation unless the mother stops nursing. As well, studies on methyldopa in pregnancy remain limited.

May precipitate or increase azotęmia; cumulative effects may develop in presence of impaired renal function; discontinue if increasing azotemia and oliguria occur during treatment of severe progressive renal disease. Use with caution in impaired hepatic function or progressive liver disease since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because chlorothiazide potentiates their action.

Use coated potassium tablets only when indicated and when adequate dietary supplementation is not practical. Nonspecific small-bowel lesions, consisting of stenosis with or without ulceration, reportedly followed use of enteric-coated potassium tablets alone or with oral diuretics. These lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Discontinue immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.

PRECAUTIONS

Methyldopa

Acquired hemolytic anemia has occurred rarely. Hemoglobin and/or hematocrit determinations should be performed when anemia is suspected. If anemia is present, determine if hemolysis is present. Discontinue methyldopa on evidence of hemolytic anemia. Prompt remission usually results on discontinuation alone or on the initiation of adrenocortical steroids. Rarely, however, fatalities have occurred.

A positive direct Coombs test has been reported in some patients on continued therapy with methyldopa, the exact mechanism and significance of which is not established. Incidence has varied from 10 to 20%. If a positive test is to develop, it usually does within 12 months following start of therapy. Reversal of positive test occurs within weeks to months after discontinuation of the drug. Prior knowledge of this reaction will aid in cross matching blood for transfusion. This may result in incompatible minor cross match. If the indirect Coombs test is negative, transfusion with otherwise compatible blood may be carried out. If positive, advisability of transfusion should be determined by a hematologist or expert in transfusion problems.

Reversible leukopenia with primary effect on granulocytes has been seen rarely. Rare cases of clinical agranulocytosis have been reported. Granulocyte and leukocyte counts returned promptly to normal on discontinuance of the drug.

Occasionally, fever has occurred within the first three weeks of therapy, sometimes associated with eosinophilia or abnormalities in one or more liver function tests. Jaundice, with or without fever, may occur also, with onset usually within first 2 or 3 months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsies in several patients with liver dysfunction showed a microscopic focal necrosis compatible with drug hypersensitivity. Determine liver function, leukocyte and differential blood counts at intervals during the first 6 to 12 weeks of therapy or whenever unexplained fever may occur. Discontinue if fever, abnormalities in liver function tests, or jaundice occur.

Methyldopa may potentiate action of other antihypertensive drugs. Follow patients carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Patients may require reduced doses of anesthetics when on methyldopa. If hypotension does occur during anesthesia, it usually can be controlled by vasopressors. The adrenergic receptors remain sensitive during treatment with methyldopa.

Hypertension occasionally noted after dialysis in patients treated with methyldopa may occur because the drug is removed by this procedure.

Rarely involuntary choreoathetotic movements have been observed during therapy with methyldopa in patients with severe bilateral cerebrovascular disease. Should these movements occur, discontinue therapy.

Fluorescence in urine samples at same wave lengths as catecholamines may be reported as urinary catecholamines. This will interfere with the diagnosis of pheochromocytoma. Methyldopa will not serve as a diagnostic test for pheochromocytoma.

Chlorothiazide

Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Advise patients to maintain adequate electrolyte intake. Should hypochloremic alkalosis or hyponatremia occur, consider appropriate therapy.

Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Hypokalemia can sensitize or exaggerate the response of the heart to toxic effects of digitalis. Prevent or treat hypokalemia with food high in potassium, or with supplemental potassium chloride. Water restriction rather than actual salt replacement may be considered appropriate treatment of any chloride deficit except in rare instances when hyponatremia is life threatening. Then appropriate salt replacement is the therapy of choice.

Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, but not sufficiently to preclude effectiveness of the pressor agent in therapy. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Pathological changes in the parathyroid glands with hypercalcemia and hypophosphatemia have been seen in a few patients on prolonged thiazide therapy. Renal lithiasis, bone resorption, and peptic ulceration have not been seen. The effect of discontinuing thiazide therapy on serum calcium and phosphorus levels may be helpful in assessing the need for parathyroid surgery in such patients.

Hyperuricemia may occur or gout be precipitated. May affect insulin requirements of diabetics. Latent diabetes mellitus may become manifest.

ADVERSE REACTIONS

Methyldopa

Cardiovascular: Angina pectoris may be aggravated; reduce dosage if symptoms of orthostatic hypotension occur; bradycardia occurs occasionally. ***Neurological:*** Symptoms associated with effective lowering of blood pressure occasionally seen include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Sedation, usually transient, seen during initial therapy or when dose is increased; similarly, headache, asthenia, or weakness may be noted as early, but transient symptoms. Rarely reported: paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, and a single case of bilateral Bell's palsy. ***Gastrointestinal:*** Occasional reactions generally relieved by decrease in dosage: mild dryness of the mouth and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea; rarely nausea and vomiting. ***Hematological:*** Positive direct Coombs test, acquired hemolytic anemia, leukopenia and rare cases of thrombocytopenia. ***Toxic and Allergic:*** Occasional drug related fever and abnormal liver function studies with jaundice and hepatocellular damage, (see PRECAUTIONS) and a rise in BUN. Rarely, skin rash, sore tongue or "black tongue", pancreatitis and inflammation of the salivary glands. ***Endocrine and Metabolic:*** Rarely, breast enlargement, lactation, impotence, decreased libido; weight gain and edema which may be relieved by administering a thiazide diuretic. If edema progresses or signs of pulmonary congestion appear, discontinue drug. ***Miscellaneous:*** Occasionally nasal stuffiness, mild arthralgia and myalgia; rarely, darkening of urine after voiding.

Chlorothiazide

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis. ***Central Nervous System:*** dizziness, vertigo, paresthesias, headache, xanthopsia. ***Hematologic:*** leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. ***Cardiovascular:*** orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics). ***Hypersensitivity:*** purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis), fever, respiratory distress, anaphylactic reactions. ***Other:*** hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

PRODUCT MONOGRAPH AVAILABLE ON REQUEST

AVAILABILITY

No. 8758—Tablets SUPRES*-150, each containing 150 mg chlorothiazide and 250 mg methyldopa, are oval, biconvex shaped tablets, coated with a beige film, with a phi mark on one side and are supplied in bottles of 100 and 500.

No. 8759—Tablets SUPRES*-250, each containing 250 mg chlorothiazide and 250 mg methyldopa, are oval, biconvex shaped tablets, coated with a green film, with a phi mark on one side and are supplied in bottles of 100 and 500.

(MC-351a)

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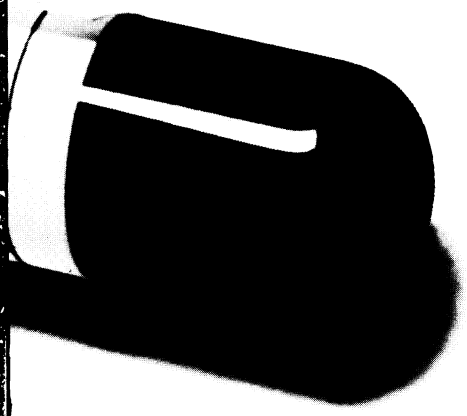
ATROMID-S* (clofibrate) is a recent winner of the most coveted pharmaceutical award in France, the Prix Galien—awarded for the decade's most significant therapeutic advance.

And small wonder, considering the relevance of this pharmaceutical achievement. For the correlation between elevated serum lipid levels and risk of atherosclerosis and heart disease is no longer seriously questioned.

ATROMID-S provides a lipid-lowering effect that is consistent and sustained. Patients accept long-term treatment easily, and adverse reactions are minimal and infrequent. The most common side effect is nausea, reported in only about 5%.

Biochemical and clinical tests have confirmed that ATROMID-S lowers serum lipids through modification of normal physiologic processes. It inhibits biosynthesis of cholesterol at an early stage and without the accumulation of toxic intermediates. ATROMID-S is Canada's most widely prescribed lipid-lowering agent.

Indications ATROMID-S is indicated where reduction of blood lipids is desirable; e.g., patients with hypercholesterolemia and/or hypertriglyceridemia. **Contraindications** While teratogenic studies have not demonstrated any effect attributable to ATROMID-S, its use in nonpregnant women of childbearing age should only be undertaken in patients using strict birth control measures. If these patients then plan to become pregnant, the drug should be withdrawn several months before conception. The drug should not be given to lactating women. ATROMID-S is not recommended in children since, to date, an insufficient number of cases have been treated. ATROMID-S is not recommended for patients with impaired renal or hepatic function. **Warning** Caution should be exercised when anticoagulants are given in conjunction with ATROMID-S. The dosage of the anticoagulant should be reduced by one-third to one-half (depending on the individual case) to maintain the prothrombin time at the desired level to prevent bleeding complications. Frequent prothrombin determinations are advisable until it has been definitely determined that the levels have been stabilized. For PRECAUTIONS and ADVERSE REACTIONS, see scientific brochure. **Dosage and Administration** For adults only: One capsule (500 mg) four times daily. **Availability** No. 3243—Each capsule contains 500 mg clofibrate N.F. in bottles of 100 and 360. Further information, references, and scientific brochure available on request.



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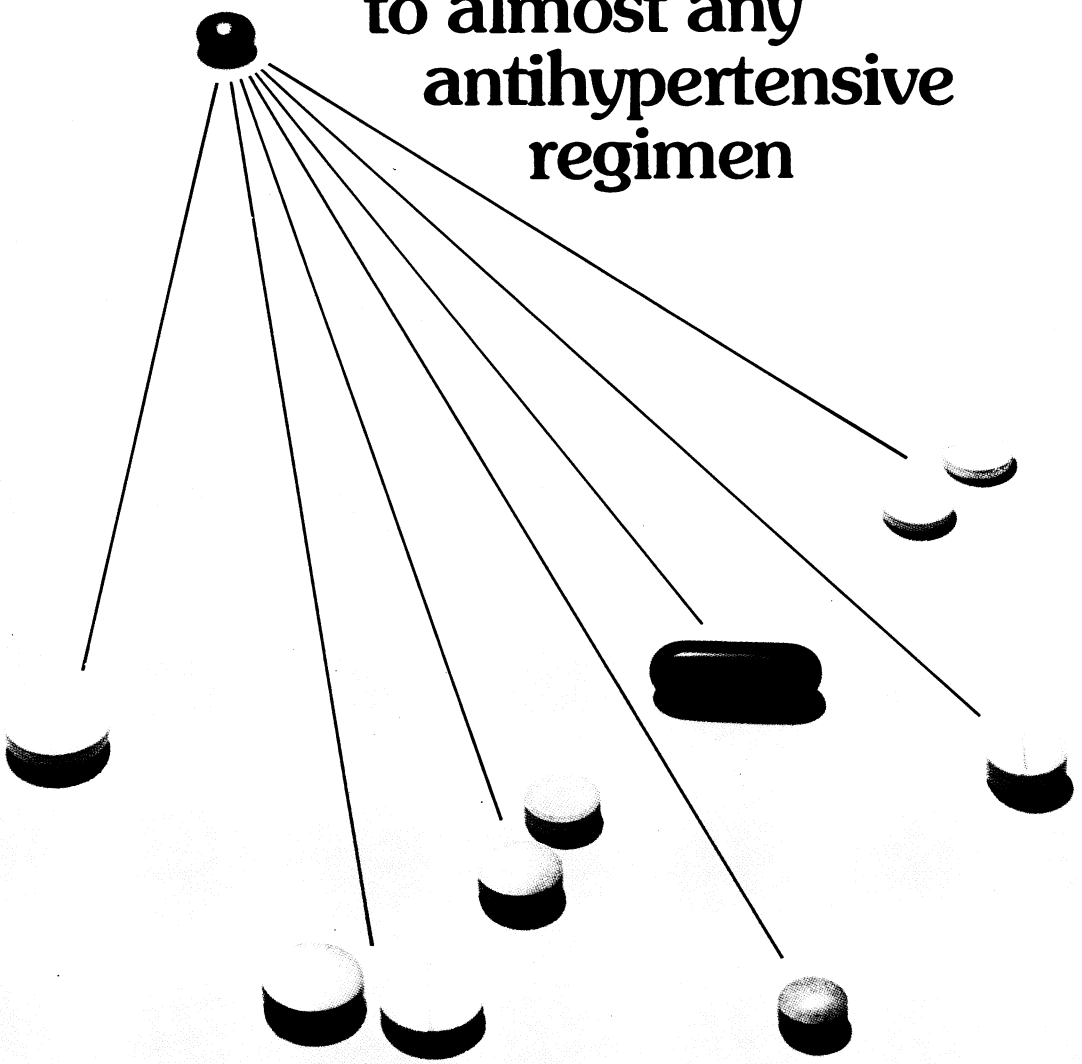
to almost any antihypertensive regimen



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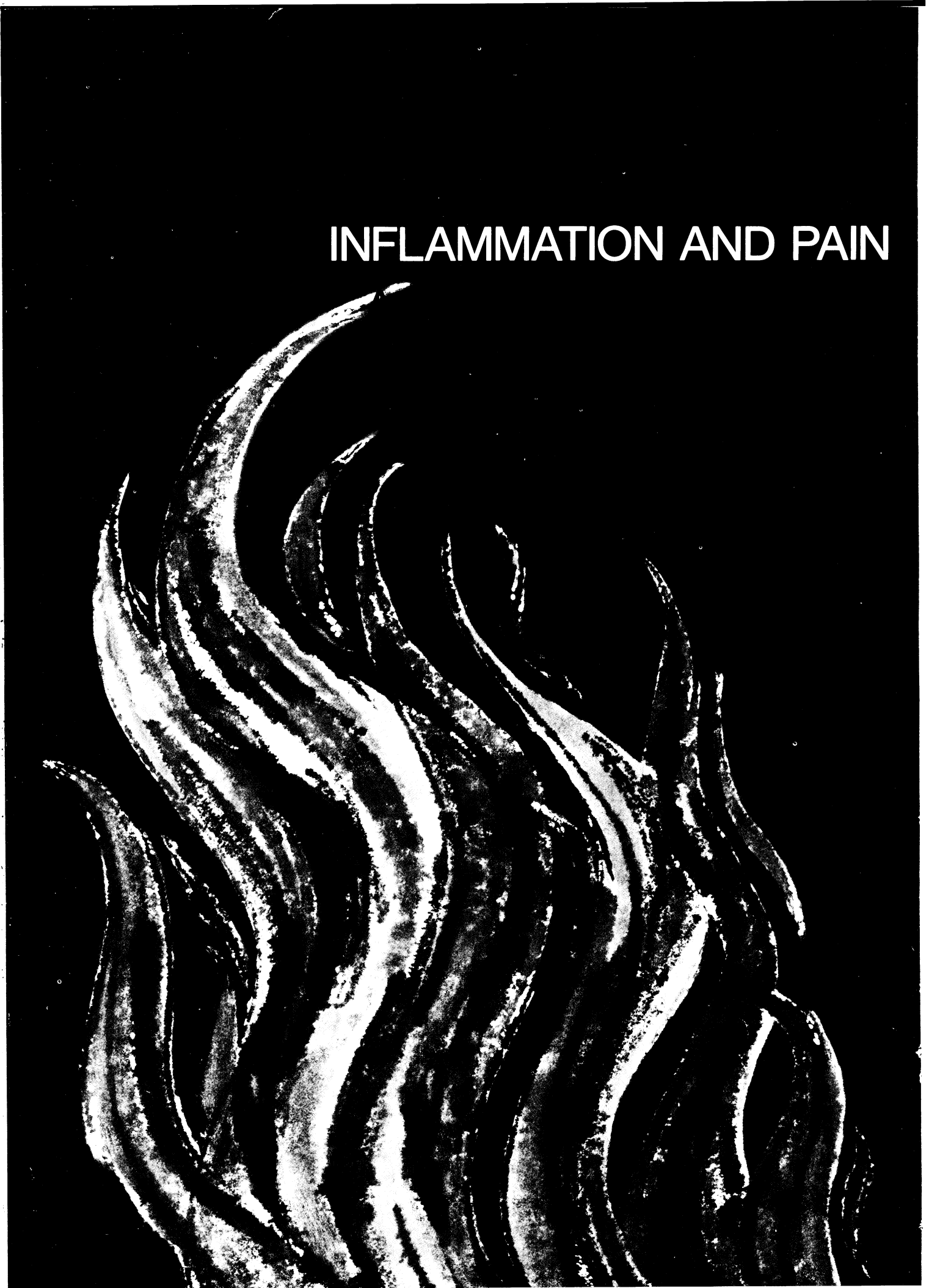
INFLAMMATION AND PAIN



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diagnosis of urinary tract infection, to institute treatment, and to have his diagnosis confirmed on urine culture. In the studied group of physicians, patients presenting frequency alone were suspected of having urinary tract infection in 61 percent of cases, but this was confirmed in only six percent. Obviously one of this present method's weaknesses is that it does not allow us to determine which other factors led to the presumed diagnosis. However, the symptom of frequency alone does not appear to be associated positively with a confirmed diagnosis of urinary tract infection.

The overall confirmation of diagnoses is 35 percent. Mond's figure was 45 percent, Gallagher's 59 percent. This may be due to inexperience of the residents in our training program, but is more likely to be an artifact caused by the data collection system whereby there is a tendency to over-diagnose conditions for the sake of naming them on the encounter form. It remains to be seen from further study whether the accuracy of diagnosis can be used as a measure for evaluating residents in training, or indeed for audit of an individual physician's performance.

The physicians studied were more likely to label the symptomatic female as having infection. The male/female ratio in all patients presenting symptoms is 1:3.3, which is less than the ratio of 1:8.8 for presumed diagnosis, and 1:8.6 for confirmed diagnosis. These figures, combined with the similar rates for accuracy of diagnosis for both males and females, suggest that although the clinical diagnosis of urinary tract infection is difficult, physicians are able to select those patients who are most likely to suffer from the condition. Apparently the presence of dysuria and frequency together, with or without other symptoms, is a major stimulus for the physician to suspect urinary tract infection.

Conclusion

The method employed in this study shows that by starting with the patient's symptoms and recording physician responses, as well as the results of investigations, we gain some insight into the significance of the symptoms, and also into the physician's performance. Although this study was based on a computerized data system in an academic setting, the subsequent method of chart review and data abstraction required only manual

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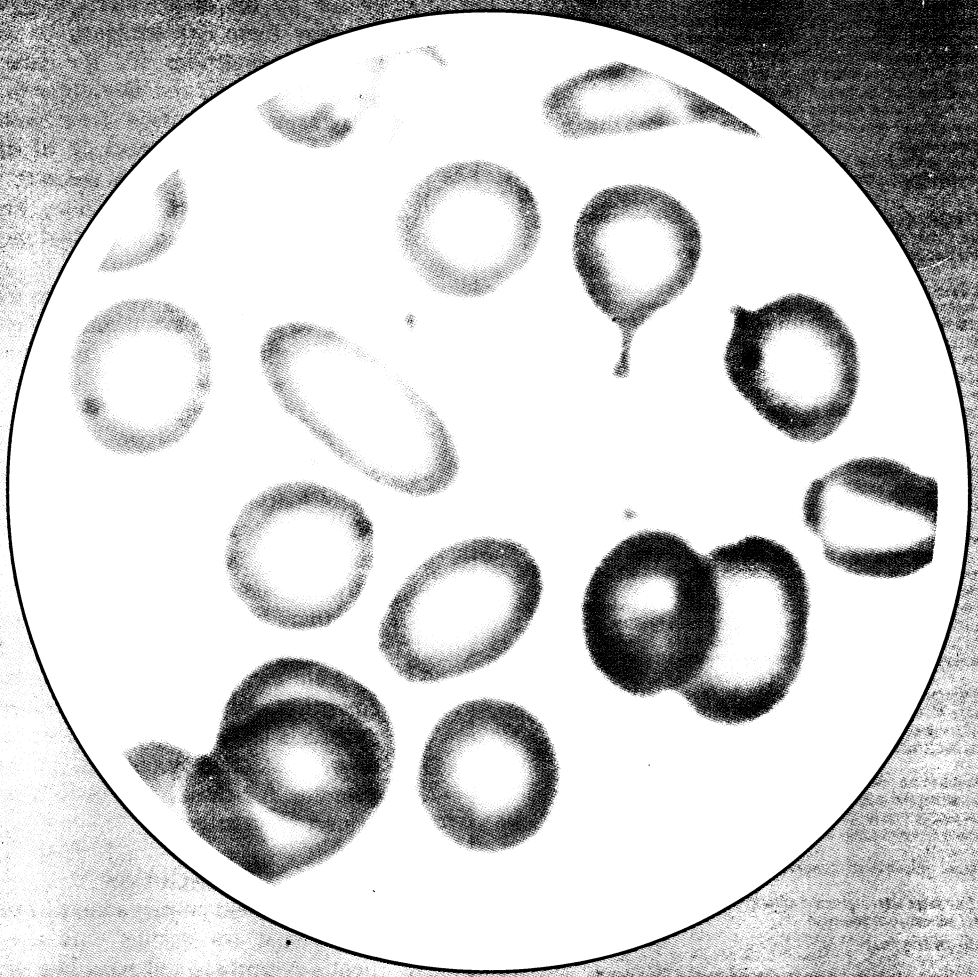

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methods and could easily be modified for use in any practice which keeps a disease index or E book. Urinary tract infection is a relatively easy condition to study in this way because the diagnosis can be definitely made on objective criteria and also the number of symptoms referable to the urinary tract is relatively small. Minimal modifications to the method would allow its use in investigating other symptom complexes. ◀

Acknowledgements

I would like to acknowledge the assistance of Miss Alison Kay in collecting data for this study, Dr. Martin Bass for helpful advice and criticism, and the fact that the original computer work at Western was funded by a Demonstration Model Grant No. 46 from the Ontario Ministry of Health.

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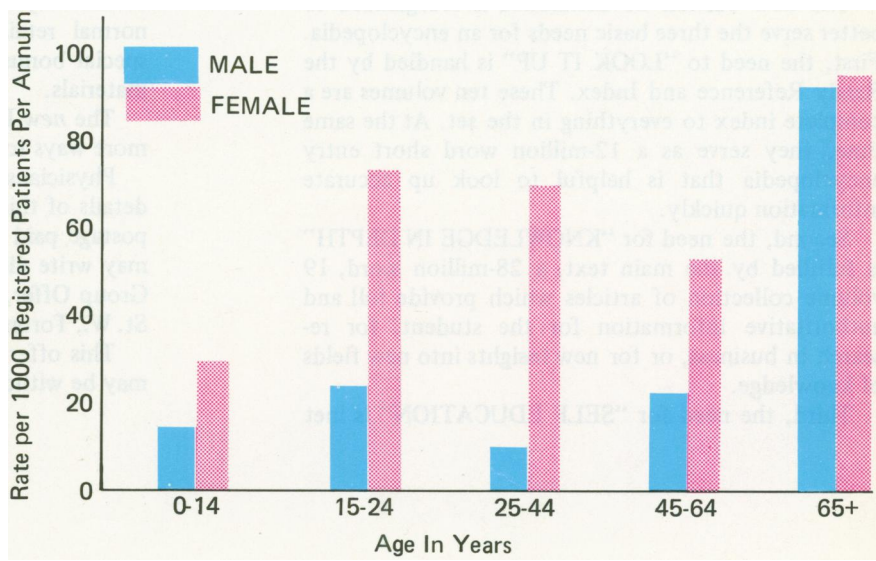
TABLE 5

Symptoms and Result of Urine Culture in Cases Initially Diagnosed As UTI

Symptoms	Cases	Culture Positive (%)	Culture Negative (%)
Dysuria only	9	2 (4.4)	7 (8.5)
Frequency only	10	1 (2.2)	9 (11.0)
Dysuria & frequency only	32	13 (28.9)	19 (23.2)
Dysuria & other	16	5 (11.1)	11 (13.4)
Frequency & other	15	5 (11.1)	10 (12.2)
Dysuria, frequency & other	32	17 (37.8)	15 (18.2)
Other only	13	2 (4.4)	11 (13.4)
	127	45 (79.9)	82 (100.0)

Fig. 1. The Annual Rate of Patients Presenting One or More Urinary Symptoms



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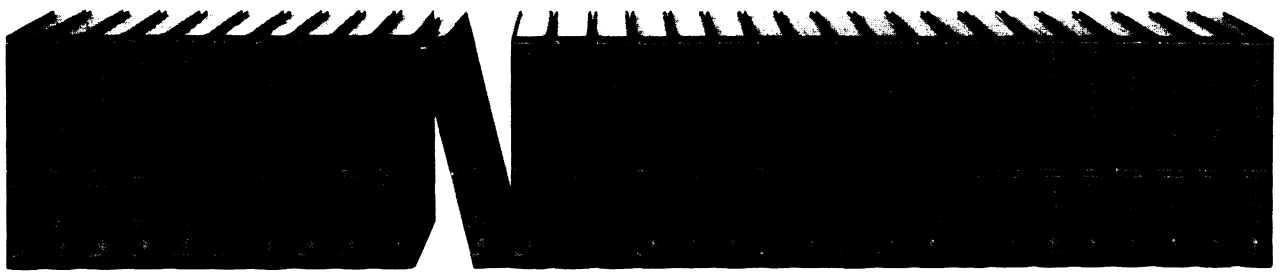

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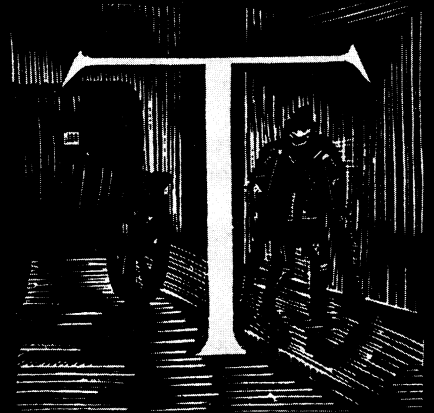

tinence. It is sometimes possible to palpate bimanually a bladder which still has considerable urine in it after the child is seen to have voided completely. All of these findings will be useful in directing the physician towards ruling out an organic cause for the enuresis.

Complete urinalysis should be done. A urine culture should also be performed, since up to 20 percent of urinary tract infections may not be reflected by white cells in the urine.

It is important when proposing a course of treatment of these children to exhibit interest and enthusiasm in one's approach. A large element of suggestion always accompanies treatment prescribed and the physician's attitude will have a strong effect on the child's performance. It is important to give the child a feeling that his own efforts will help to improve his bladder control. In the younger ages, one may provide rewards, but physical punishment is to be avoided. It is important to explain fully to the child to the level of his understanding, what the program of treatment is, and what you expect from it.

If there are some environmental factors which may be obvious, solutions for these should be suggested. The most common problem may be unsuitable sleeping accommodation. Primary concern, however, is with developing a voiding habit which allows the bladder capacity to increase to the point where the child can void before bedtime and then sleep through the night, getting up to void first thing in the morning.

It is now our practice not to treat any enuretic under age five since the vast majority of these children will stop spontaneously. Recent publications suggest that the drug we use most commonly (imipramine) may be dangerous for patients under age five. Once a child reaches age six, we begin by giving them a combination of imipramine therapy and a calendar system, on which the child keeps track of his own progress and brings it to the physician once every 30 days in order to have his improvement reinforced.

Imipramine is given in doses of 10 mg, two hours before bedtime. In younger children this may be increased to 25 mg and in older children to 50 mg. It is important to continue the treatment for a minimum of three months, since very often, stopping the drug before this may result in relapse. It is useful also to taper the drug off at the end of the three month period by reducing the dosage and giving it every other day in order to wean the child slowly. Occasionally we have found that the use of propantheline 7.5 or 15 mg given at the same time as the imipramine has helped some children who remain resistant to imipramine alone. In our experience, other drugs have been of little use.

The other regimen that we have found useful is the use of an alarm system. It has been our practice not to use this type of system in children under the age of ten. Above this age, an alarm system is used only after the child has been fully studied radiologically with intravenous pyelonegraphy and a voiding cystourethrogram, to establish that there are no significant abnormalities of the urinary tract. Once this has been established, the alarm system has been particularly successful with older children.

Psychiatric help is certainly appropriate for those children who appear to have definite emotional disturbances, or for whom there has been a clear episode of an emotional nature which is precipitating the enuresis.

Finally, endoscopic and surgical methods of treatment are applicable only where unquestionable pathology has been demonstrated in the course of investigating a child with enuresis. The use of urethral dilatations and other manipulations as a primary treatment for enuresis is inappropriate.

In summary, most children who are enuretic, are so on the basis of an immature bladder mechanism. In most children this enuresis will improve and disappear by the time the child is five or six years of age. It is wise to remain somewhat skeptical about all methods of treatment in enuresis since over a period of years from the time of onset of treatment almost all children with enuresis will become dry. ◀

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- pyelitis
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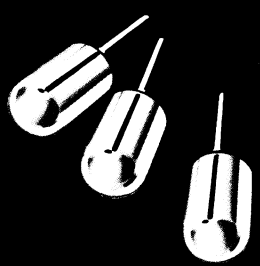

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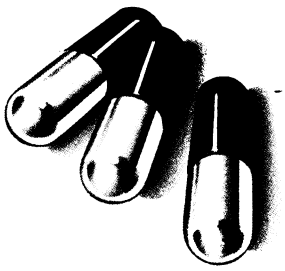

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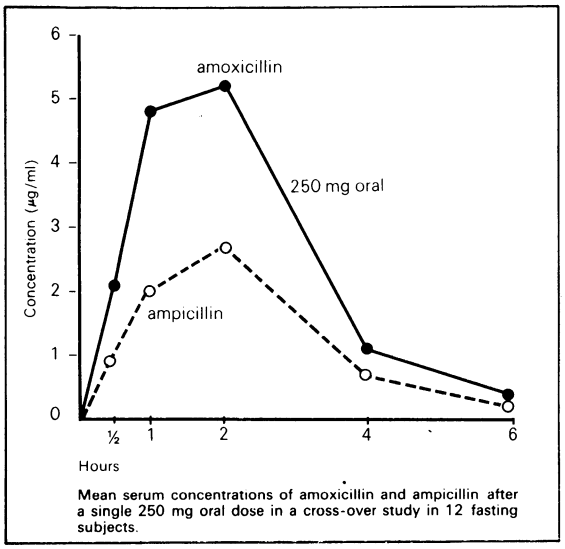

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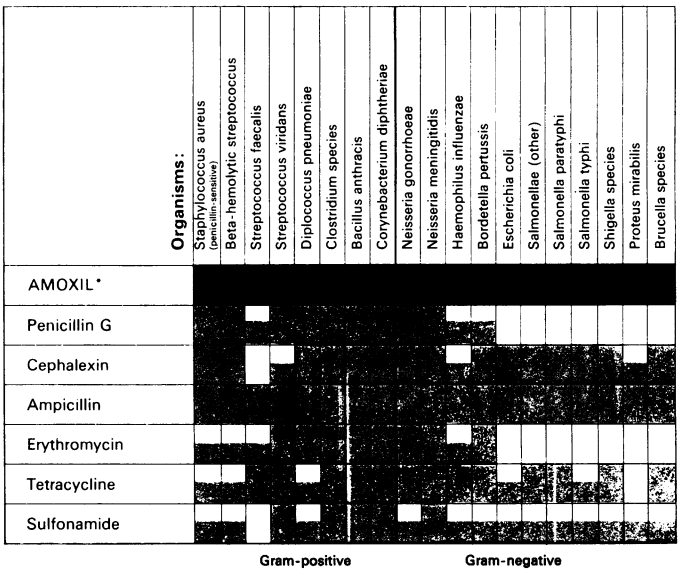

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"Refined sugar of all kinds, including sucrose, fructose, glucose, and honey, may be dangerous for persons with a genetic disposition to diabetes, Dr. A. M. Cohen, Professor of Medicine at the Hebrew University Hadassah Medical School in Jerusalem, warned at a recent meeting of the American Chemical Society here.

He based his warning on a 15-year study of Yemenite Jews immigrating to Israel. "Before they came here, the Yemenites did not know of sucrose and never used it", he said. "We examined about 6,000 of them some 20 years ago and found almost no diabetes at all. Today, after living on the 'Westernized' diet in Israel, every sixth Yemenite over age 30 – about 15 percent of this group – is diabetic".

Testing these observations, Dr. Cohen carried out experiments in laboratory animals: some were put on "Yemenite" diets, others on "Western" regimens. After two months, the animals were tested for glucose tolerance. Those on "Yemenite" diets were found to be normal, while the others had impaired glucose tolerance, Dr. Cohen said. Lipid metabolism and growth rate also suffered in the "Westernized" group, he added. When he repeated the same experiment in human volunteers, results were the same . . .

He even suggested that packages of sugar should carry a warning similar to that on tobacco products, and that more importantly, physicians and educators should instigate a national plan to start children from birth on a low-sugar diet.

Dr. Cohen also stressed that fructose, "considered in many countries as a diabetic sweetener", is no different from sucrose as a diabetogenic nutrient. Moreover, the use of honey is also unsafe for diabetic-prone individuals, he added. Some commercial bees are even fed sucrose to increase the honey yield, he explained. "To feed a diabetic or a child large amounts of any of these sugars is noxious and dangerous", he told the press.

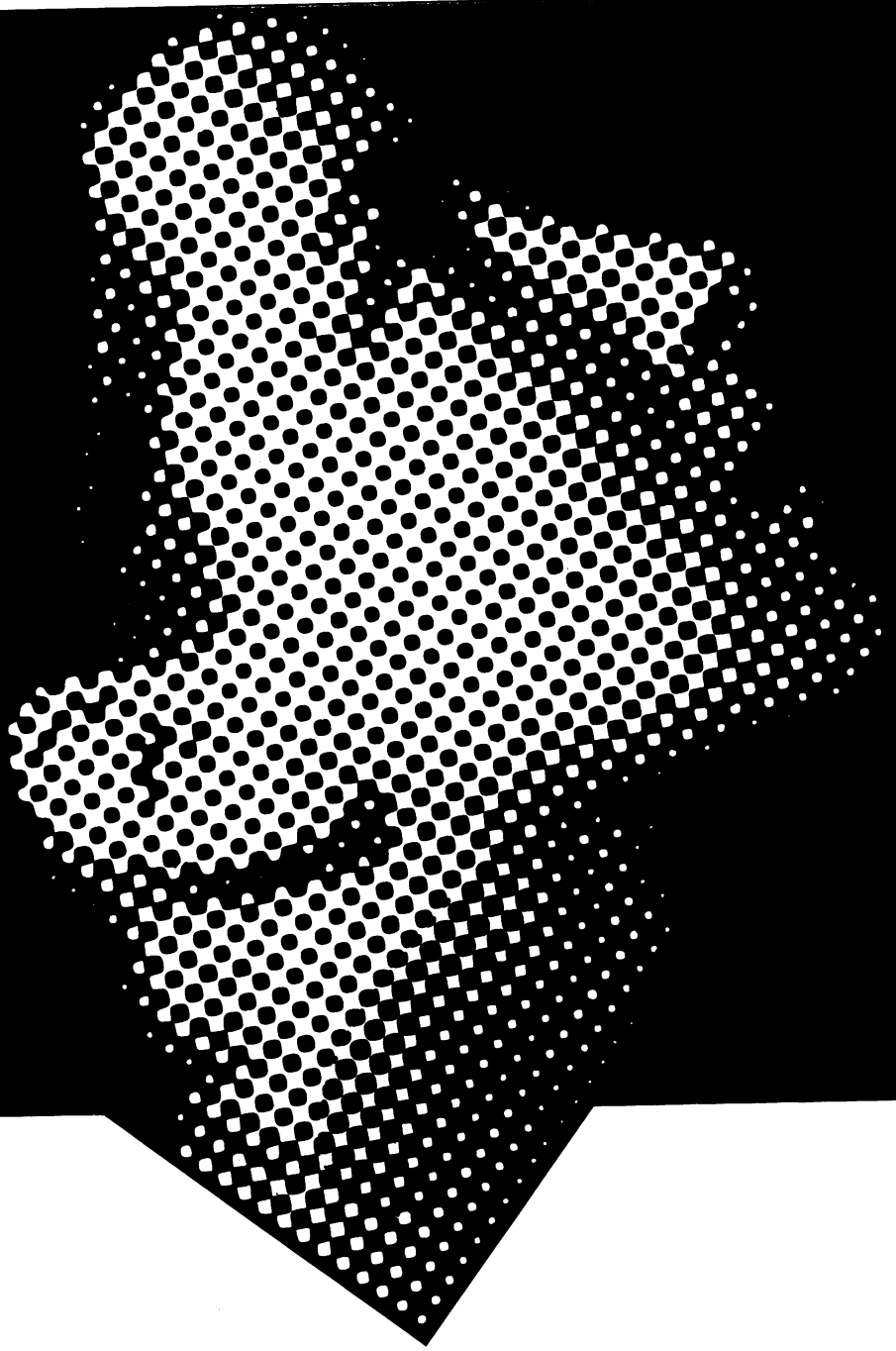
As a substitute, Dr. Cohen recommended starches. "I am against a hunger diet, and I know there are many things men can enjoy without eating sugar", he said."

Medical Tribune, October 22, 1975.

Dietary Potassium: How Much is Enough?

"An important consideration in the study of total body and serum potassium levels during prolonged thiazide therapy for essential hypertension is the dietary intake of potassium, especially in the elderly. Dietary deficiency of potassium is commonly believed to be rare in man. Secondary potassium deficiency is very common after prolonged diuretic therapy and in many disease states. In hospitals, potassium deficiency can be observed in patients receiving parenteral nutrition. Since the serum-potassium level is a poor indicator of general body status of potassium, potassium deficiency is difficult to diagnose. Serum levels of potassium may remain normal even after moderate depletion of total body potassium . . .

Studies . . . support the belief that dietary deficiency of potassium can occur in man, especially in the elderly. At present, there is no internationally accepted minimum daily requirement of potassium. The figures available are based on balance calculations. According to Weisberg, the intake of potassium to balance average losses should be approximately 65 meq. per day,



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and Judge has recommended a daily minimum intake of 60 meq. The true values are difficult to estimate, but they probably lie around 50-60 meq. a day.

With these facts in mind, we have investigated the content of potassium in 245 daily food portions of a group of 67-year-old pensioners (n = 37) in southern Sweden by double-portion technique. The double portion is a copy as exact as possible of the food and drink consumed during one day. The pensioners had a daily median intake of 53 meq. for men and 44 meq. for women. Only 6 out of the 17 male and 3 out of the 20 female pensioners had a daily potassium intake over 60 meq. If we accept 50-60 meq. as the normal daily requirement, almost the whole group had a relatively low daily intake. Elderly women seem to be affected more seriously. This factor may be of great importance when elderly patients with hypertension are subjected to prolonged diuretic therapy. At the moment we are investigating the daily intake and elimination of potassium in a large group of women with hypertension. We have also observed that low potassium intake is always associated with a low magnesium intake.❞

Swedish physicians' letter in The Lancet, September 20, 1975.

Polio is Forgotten But Far From Dead

❝Poliomyelitis provides one example of the modern problem of epidemiological surveillance of a formerly epidemic infection which has almost disappeared as a result of effective control measures. Reduced awareness of this now unfamiliar disease may not only encourage neglect of the immunization that is essential for continued control of poliomyelitis but can also decrease the accuracy and speed of clinical recognition of cases. Notifications could then give a falsely optimistic impression of the degree of control of the disease. Virological data from diagnostic laboratories will not reveal the true situation unless clinical suspicions have caused specimens to be sent to the laboratories.

During the five years 1970-74 11 cases of paralytic poliomyelitis were detected in Scotland. Polioviruses were isolated from three incompletely or unvaccinated adults, two type 1 and one type 2 — the last being vaccine-recipient-associated. From the other eight no virus was isolated because fecal specimens were submitted too late or not at all — in one case not until an orthopedic surgeon was consulted about weak and wasted thumb muscles. Serological tests were too late to detect diagnostic rising antibody titres, but unusually high titres suggested recent poliomyelitis in all. Provisional diagnosis had included multiple sclerosis, neurological and psychiatric disorders. The patients diagnosed serologically included four children (three preschool) and four adults. One illness started in Majorca and one shortly after return from Spain, both involving adults — a reminder that immunity to poliomyelitis may be as important as that to typhoid for visitors to our usual warm, sunny vacation resorts.❞

Physicians' letter in the British Medical Journal, August 2, 1975.

Rising Numbers of Teenage Smokers

❝Surveys indicate that the number of U.S. teenagers who regularly smoke cigarets has increased from 12 percent in 1968 to 16 percent in 1974, Dorothy E. Green, PhD, said at the World Conference on Smoking and Health sponsored by The American Cancer Society and the National Cancer Institute.

The increase in smoking has taken place almost exclusively among girls, said Dr. Green, a consultant research psychologist from Arlington, Va. The surveys also indicated that teenagers from homes with one parent were more likely to smoke than teens from homes with both parents, she continued. Smoking occurred more often among teens with less educated parents than among those with better educated parents.

Teens with parents who used cigarets were more likely to smoke than those with no parent who smoked, and the likelihood of a teenager smoking was amplified if a parent and an older sibling smoked, Dr. Green said.

Smoking among teens was influenced by peer groups as well as by the family. Nine out of ten teenagers who smoked acknowledged that at least one of his four best friends smoked on a regular basis; only one in three nonsmoking teens acknowledged a smoker among his four best friends.❞

Family Practice News, September 15, 1975.

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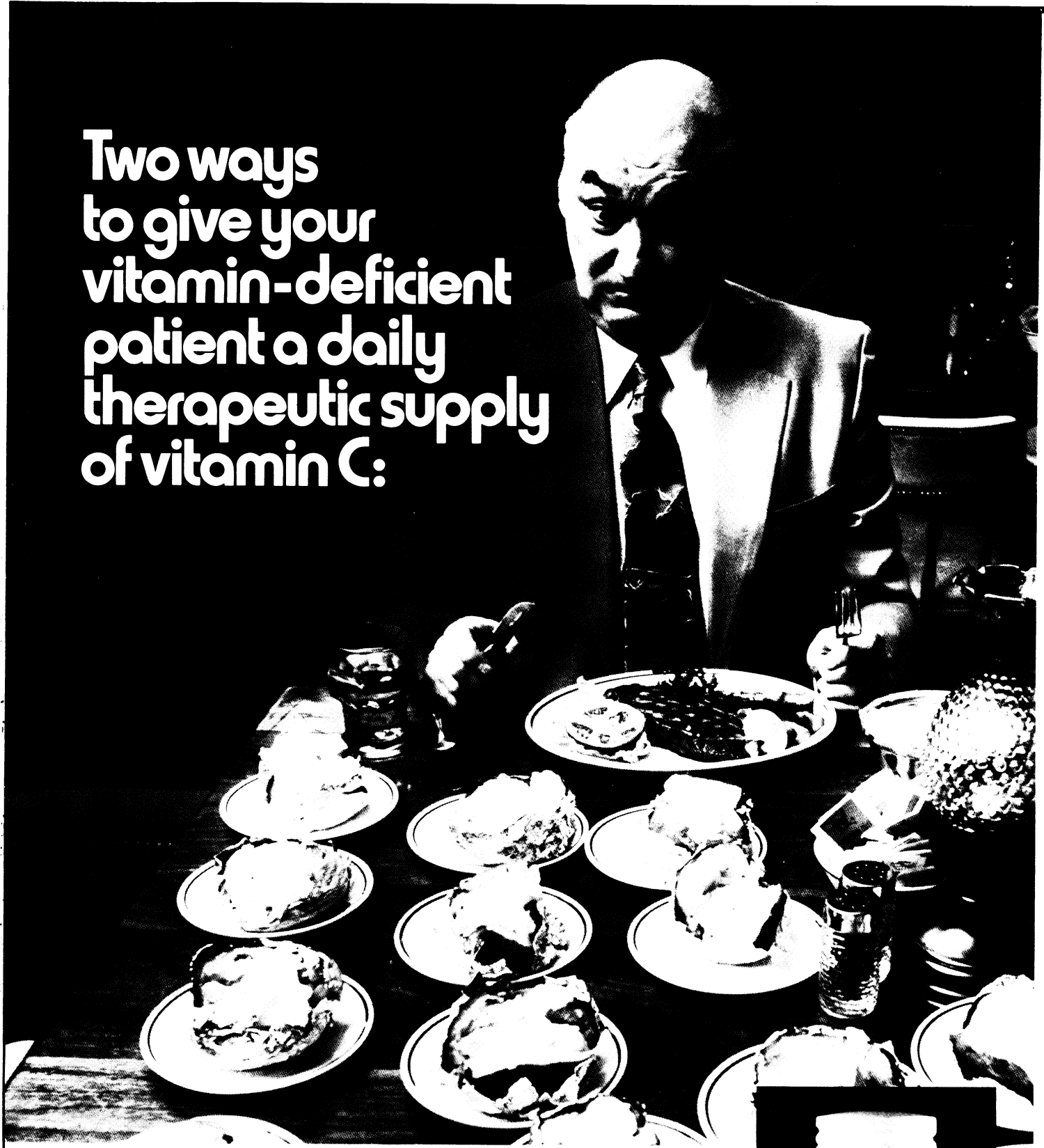

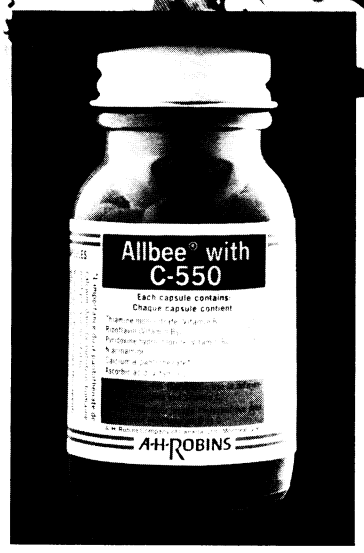

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Preceptors are asked to take students for one, two, or three month periods. Interested physicians should fill out the form below and mail it to the Ontario Chapter office.

Ontario Preceptorship Program

Name:_____

Address:_____

_____

_____

College member
yes ☐ no ☐

Certificant in family medicine
yes ☐ no ☐

Willing to participate for one ☐
two ☐ three ☐ months.

Previous participant:
yes ☐ no ☐

Mail to:

Chairman,
Undergraduate Education Committee,
Ontario Chapter,
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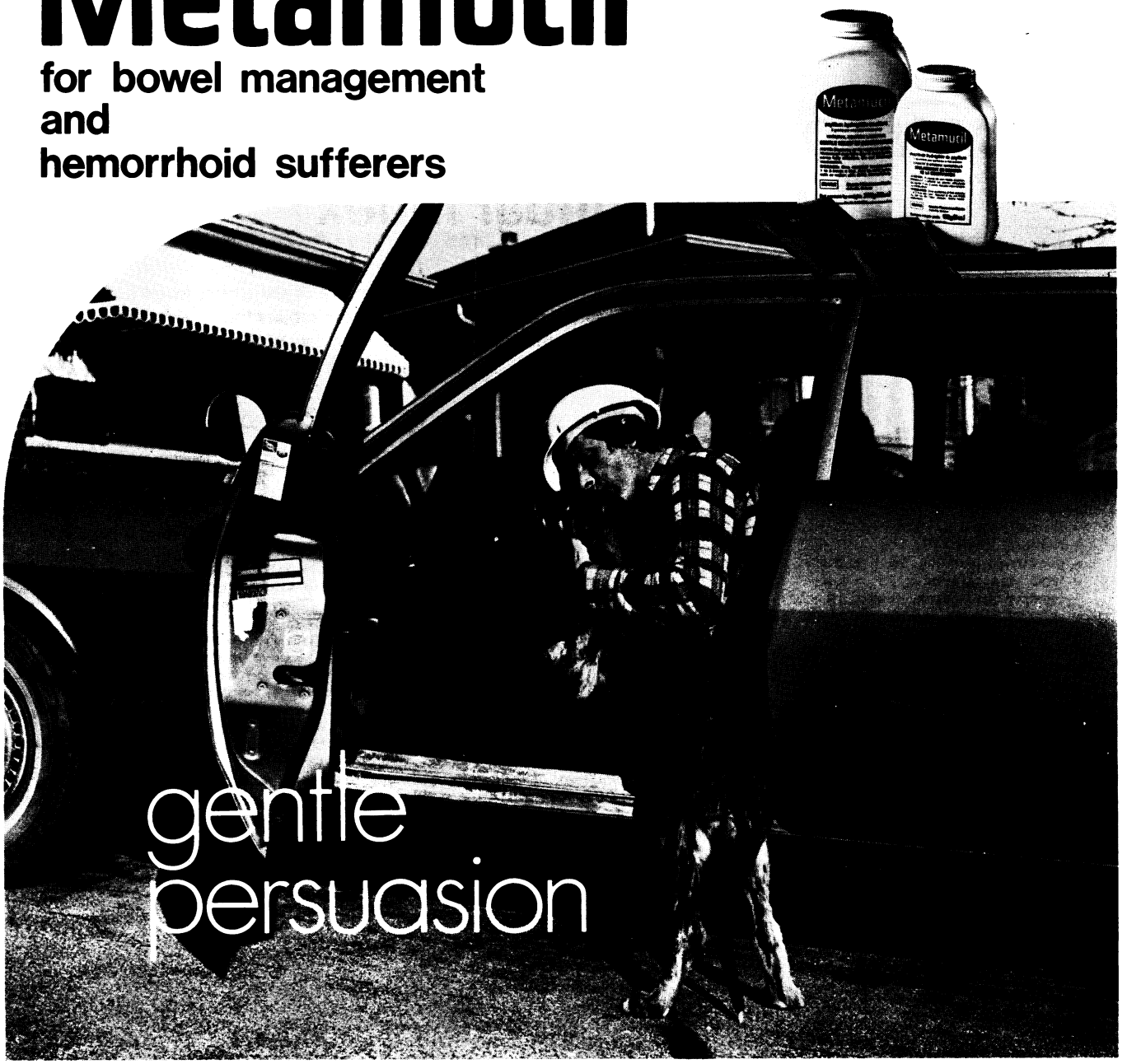

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— The Treatment of Alcoholism (Larkin), July p. 102
— The Treatment of Chronic Pain (Hart), Sept. p. 146
— Twenty Years of Community Medicine (Curry et al.), May p. 137
— The Way Your Body Works (Stonehouse), Aug. p. 93
— The Womanly Art of Breastfeeding (La Leche League), April p. 129
bowel disease, low fiber diet and, May p. 21

C

cancer
— le cancer chez l'enfant, jan. p. 149
— diagnosis, colposcopy in cervical, Sept. p. 32
— diagnosis, scintiscan methods in, Jan. p. 79
— educating the public, April p. 9
— fear of, Jan. p. 98
— herpes, immunological study of, Oct. p. 19
— l'information du public, mai p. 145
— pain control in terminal, Jan. p. 72
— pap smears, evaluating abnormal, Jan. p. 75
— research award, May p. 29
— trends in management of, Jan. p. 69
— volunteers, Jan. p. 103
carbohydrates in metabolism, April p. 69
CARD program, Aug. p. 22
career characteristics of family medicine residents, Feb. p. 151
CARES, abortion referral service, March p. 7, April p. 159
cervical disc lesions, cause of headache, March p. 17
cholesterol, no safe level of, Dec. p. 20
College of Family Physicians of Canada
— l'admissibilité des candidats à l'examen de certification, 1976, nov. p. 114
— Board of Directors' meeting, May p. 9, Sept. p. 9
— certification examination, March p. 15, p. 118; July p. 17; August p. 9
— conseil des directeurs, juin p. 158; Oct. p. 140
— examen de certification, 1975, août p. 101
— future of, June p. 9
— l'histoire du, juillet p. 106
— history of, June p. 13; (letter), Aug. p. 16
— involvement with WONCA, June p. 41
— journal, l'histoire du, juillet p. 104
— journal, history of, June p. 6
— President's view of, June p. 37
— les principaux travaux en 1975, fév. p. 162
— les priorités en 1975, mars p. 155
— priorities for 1975, Feb. p. 9
— relations with OMA (letter), Jan. p. 20
— research by, June p. 33
child
— behavior, abnormal, Oct. p. 56
— birth, (editorial) May p. 7; physical examination at, Oct. p. 20
— developmental assessment of, May p. 58
— learning disorders in, March p. 82
— obesity, preventing, April p. 72
— parent interaction, May p. 63
— school phobia and the role of mothers, Nov. p. 24
chronic illness register, modified E book, July p. 35
classification of diseases, Feb. p. 49
clindamycin, unusual reaction to, (letter), May p. 15
clinic, community, Carnduff, Sask. (letter), Jan. p. 21
cluster headache (letter), Feb. p. 13
cold, common, (letter), Jan. p. 21
colitis, drug therapy for, April p. 19
collagen diseases, diagnosis and assessment of, Feb. p. 78
communication
— appeler les choses par leur nom, nov. p. 113
— basics in human communication (editorial), Oct. p. 7
— in family practice, May p. 43
community hospital, medical students in, Oct. p. 114
consent
— need for written, Sept. p. 53
— problems of, Jan. p. 39
contracting costs, Feb. p. 35
contraception
— blindness blamed on pill, April p. 21
— IUD a passing phase, Sept. p. 33
— parental consent for minors, Sept. p. 55
coroner's inquest, March p. 47
correctional medicine, association of, (letter), Sept. p. 21
cosmetics
— a minor hazard, Nov. p. 24
— recall of, March p. 31
costs of medical practice, March p. 39
court, the doctor in, April p. 39
credit, medical charge card (letter), Sept. p. 19

D

data collection in family practice, April p. 47
day care, psychiatric, Oct. p. 61
depression, etiology of, Sept. p. 45
developmental assessment of children, May p. 58
diabetes in pregnancy, Dec. p. 19
disability, assessing permanent, July p. 60
disease, etiology of, in Africa, Jan. p. 31
distal urethral stenosis in the female, Dec. p. 47
doctor-patient relationship, conflicts in, Sept. p. 67
Down's syndrome, increase in younger mothers, July p. 23
drogue, les nouveaux visages de la, mars p. 157
drugs
— adequate information lacking on, April p. 22
— adverse reactions to, Nov. p. 67; (letter), July p. 13
— advertising code for non-prescription, Feb. p. 19
— advertising in medical journals (editorial), Nov. p. 7
— diagnosis before prescribing, Oct. p. 17
— distribution of illicit drugs in Canada, Feb. p. 25
— educating the aged, June p. 61
— mind altering, use of, Oct. p. 19
— mood-modifying, alternatives to, Nov. p. 60
— neurological disorders and, Nov. p. 52
— preclearance of ads, Aug. p. 23
— prescribing psychotropic, Nov. p. 60
— reaction to, Oct. p. 21
— road accidents and, May p. 29
— therapy, optimizing, Oct. p. 21

E

E book
— modified to Chronic Illness Register, July p. 35
— use of in family practice, Oct. p. 29
écriture médicale, août p. 100
edema, idiopathic cyclic, Aug. p. 52
education
— objectives for training family physicians, April p. 117
— undergraduate, by community physicians, June p. 127
elderly, social needs of, Nov. p. 85
emergencies, psychiatric, Oct. p. 68
emergency dept.
— care, by family physicians, Sept. p. 31

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See prescribing information, Page

— Ottawa Civic Hospital (letter), Jan. p. 23
— utilization of, Jan. p. 115
— utilization and social class, Feb. p. 117
encephalitis, Western, May p. 31
endocrinology, hypothalamic hormones, Aug. p. 45
enfant, le cancer chez l'enfant, jan. p. 149
Epidemiological Bulletin, April p. 17
epiglottitis, prevalence of, Aug. p. 55
epistaxis, serious cases of, June p. 59
euthanasia
— legal aspects of, June p. 72
— passive, July p. 22
exercise testing, graded, March p. 102
eye examination
— basic, June p. 107
— of the newborn, May p. 67
eye injuries, Nov. p. 25

F

family dynamics, Sept. p. 37
family physician
— educational objectives for, April p. 117
— term a misnomer (letter), Feb. p. 15
family practice
— CFPC and, June p. 37
— communications in, May p. 43
— data gathering in, April p. 47
— growth projections for academic, Jan. p. 135
— profile of, Sept. p. 113
— prospective medicine and, June p. 56
— research in, Feb. p. 52
— residents and the learning process, Aug. p. 86
— residents, career characteristics of, Feb. p. 151
— rural, (letter), March p. 17
— small town, April p. 35
— students, social worker teaching, May p. 117
— teacher training programs for, Oct. p. 17
— teaching programs, student acceptance of, Oct. p. 114
— training, current status of, July p. 9
— unit, physical therapy in, Sept. p. 100
family therapy, Oct. p. 53
fear in cancer patients, Jan. p. 98
fees, doctors', (letter), Feb. p. 13
fetal maturity, determining, Sept. p. 32
fetus, personality of, (letter), Aug. p. 16
fiber, low fiber diet and bowel disease, May p. 21
financial planning for families, Jan. p. 45
food, nutritional value of, (editorial), April p. 7
foot problems, ill-fitting shoes cause of, June p. 65
formation, la formation en médecine familiale, sept. p. 151

G

genetic counselling, Sept. p. 33
genetics, understanding, June p. 57
genitourinary malignancies, diagnosis and treatment, Dec. p. 38
geriatrics
— neglect of the aged, July p. 19
— social problems of, Nov. p. 85
German measles, testing in pregnancy, Feb. p. 83
gonorrhea
— epidemiology of control, May p. 99
— management of acute, May p. 112
— spectinomycin in treatment of, May p. 107

H

Halifax Youth Clinic, Nov. p. 60
hand injuries, treatment of, July p. 46
handicapped, therapy for, Nov. p. 30
HCG in treating obesity, March p. 27
health care
— complaint hearings in Ontario, Aug. p. 19
— evaluation seminar, June p. 91
— in Canada, Jan. p. 31
— new literature on, and the law, Feb. p. 29
— patients' attitudes towards, (editorial), Sept. p. 7
— planning by physicians, March p. 27
— research, issues in, Aug. p. 35
health centre, attitudes towards rural, (letter), Oct. p. 13
health guide for travellers (letter), Nov. p. 15
heart
— ischemic heart disease linked to soft water, May p. 26
— marijuana and coronary disease, Aug. p. 23
— myocardial infarction, treatment of, Jan. p. 32
— physical exercise and post coronary rehabilitation, Sept. p. 121
— stroke rehabilitation, Dec. p. 20
— high risk of disease in, Dec. p. 20
— ventricular premature beat, March p. 28
hematuria, Dec. p. 44
Henderson Family Practice Centre, Oct. p. 79
herpes, immunological study of, and cancer, Oct. p. 19
Hippocratic oath, legal implications of, Feb. p. 39
hormones, hypothalamic, Aug. p. 45
hyperactivity in children, July p. 25
hypertension
— diagnosis, precision in, July p. 21
— nature and treatment of, March p. 57
— therapy, effective, July p. 20
hyperventilation (letter), Feb. p. 15
hypoglycemia, June p. 47
hypoglycemics
— heart disease and oral, March p. 25
— the UGDP study of oral, Nov. p. 57

I

Idiopathic Cyclic Edema syndrome, Aug. p. 52
immunology, recent advances in, Feb. p. 69
income
— absence affecting, Oct. p. 25
— creating adequate, Aug. p. 29
— distribution formula, April p. 31; March p. 41
— tax write-offs, Aug. p. 29
infant
— asphyxiated newborn, resuscitation, May p. 71
— birthweight and bottle-feeding, July p. 19
— eye examination, May p. 67
— health in outpost area, May p. 75
— mortality in Northern Ontario, May p. 75
— obesity, preventing, April p. 72
inflammations génitales, anomalies congénitales et, déc. p. 74
influenza in Canada, Feb. p. 26
injection and aspiration of joints, tendons and bursae, Sept. p. 84
insurance forms, Jan. p. 41
International Women's Year, Canadian physicians and, Dec. p. 71
internship, incentive plan in Sask., Oct. p. 23
IPMA of America, Feb. p. 29

J

Jamaican Medical Congress, Jan. p. 20

K

Köbner phenomenon, psoriasis and varicella, Feb. p. 84

L

labels, self-adhesive, (letter), Aug. p. 17
learning

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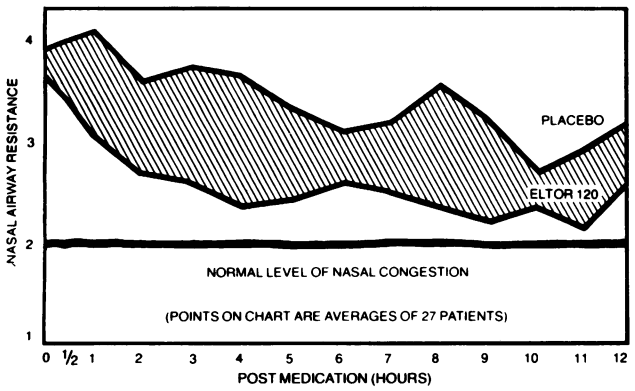

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McCAFFERY, M., Nous avons survécu, juillet p. 104
McCAFFERY, M., L'excision du verbiage, août p. 100
McCAFFERY, M., "Si on ne s'en charge pas, on se fera damer le pion? "C'est déjà fait, Sept. p. 150
McCAFFERY, M., "Je n'y ai rien compris, mais ça doit être bien", Nov. p. 113
McCAFFERY, M., Achète-t-on notre silence? Dec. p. 73
MYRES, A. W., Obesity: It is Preventable In Infancy and Childhood? Apr. p. 73

N

NEWELL, J. P., Information From Family Practice — Why and How? Apr. p. 47
NIELSEN, J. S., Pain Control For Terminal Cancer Patients, Jan. p. 72

O

O'BRIEN, D. B., Retinal Detachment, June p. 112
O'REGAN, J. B., Short Term Treatment of Phobias, Oct. p. 64

P

PERSAD, R. L., The Management of Acute Gonorrhea, May p. 112

R

RACINE, P., Anomalies congénitales et inflammations génitales, déc. p. 74
RAJPUT, A. H., Drug Therapy in Common Neurological Disorders, Nov. p. 52
RAYMOND, R., Le cancer chez l'enfant, jan. p. 149
REDDEN, C. S., Make Your Wife a Partner In Financial Planning, Jan. p. 45
REDDEN, C. S., Office Organization, Feb. p. 33
REDDEN, C. S., Rising Costs of Practice and What You Can Do About Them, Mar. p. 39
REDDEN, C. S., Income Division In Groups: Dealing With Dissatisfaction, Apr. p. 31
REDDEN, C. S., Communications in Practice, May p. 43
REDDEN, C. S., Patient Flow In A Well Organized Office, June p. 83
REDDEN, C. S., Let Your Records Work For You, July p. 31
REDDEN, C. S., Recruiting Medical Staff, Aug. p. 25
REDDEN, C. S., Life Insurance, Sept. p. 47
REDDEN, C. S., Finding Time While Making Money, Oct. p. 25
RICE, D. I., What Can We Expect in 1975? Jan. p. 17
RICE, D. I., College Priorities For 1975, Feb. p. 9
RICE, D. I., The Family Physician and Public Education, Apr. p. 9
RICE, D. I., First Board of Directors' Meeting in New College Headquarters, May p. 9
RICE, D. I., The College Comes of Age, June p. 9
RICE, D. I., Family Medicine Training in Canada's Universities: Current Status, July p. 9
RICE, D. I., 1975 Certification Examination in Family Medicine, Aug. p. 9
RICE, D. I., Highlights From Semi-Annual Meeting, CFPC Board of Directors, Sept. p. 9
RICE, D. I., An Open Letter to Students and Residents Planning Careers in Family Medicine, Oct. p. 9
RICE, D. I., Nos membres sont mécontents, jan. p. 147
RICE, D. I., Que nous réserve 1975? fév. p. 162
RICE, D. I., Les priorités du Collège en 1975, mars p. 155
RICE, D. I., Le médecin de famille et l'information du public, mai p. 145
RICE, D. I., Le Conseil tient sa première réunion dans notre nouveau secrétariat, juin p. 158
RICE, D. I., Le Collége atteint sa majorité, juillet p. 106
RICE, D. I., 1975 examen de certification, août p. 101
RICE, D. I., La formation en médecine familiale dans les universités du Canada à l'heure actuelle, Sept. p. 151
RICE, D. I., Faits saillants de la deuxiéme réunion semestrielle du Conseil des Directeurs, Oct. p. 140
RICE, D. I., Lettre ouverte aux étudiants et résidents qui se destinent à la médecine familiale, Nov. p. 114
ROSENBAUM, P., Parent-Child Interaction in the First Year of Life, May p. 63
ROY, R. G., BARRY, R. E., Town and Gown Unite in Collaborative Program, June p. 127
ROZOVSKY, L., Reporting Incidence: A Legal Viewpoint, May p. 91

S

SCHATZ, D. L., How to Lose Weight? A Multiple Choice Question For The Patient, Apr. p. 87
SHEPHARD, R. J., Perspective On Air Pollution: The Canadian Scene, Aug. p. 67
SIMARD-MAVRIKAKIS, S., Le traitement de l'obésité, avril p. 162
SMITH, S. G., The POMR As a Teaching Aid, Sept. p. 140
SMITH, V. A., GOLUBOFF, S., Psychiatric Emergencies In Family Medicine, Oct. p. 68
SPASOFF, R. A., Patients' Attitudes Towards a Rural Health Centre, Aug. p. 59
SPASOFF, R. A., Time and Money in Family Practice, Nov. p. 37
ST. GEORGE, I., Patients and Students: An Attitudinal Survey, Apr. p. 102

T

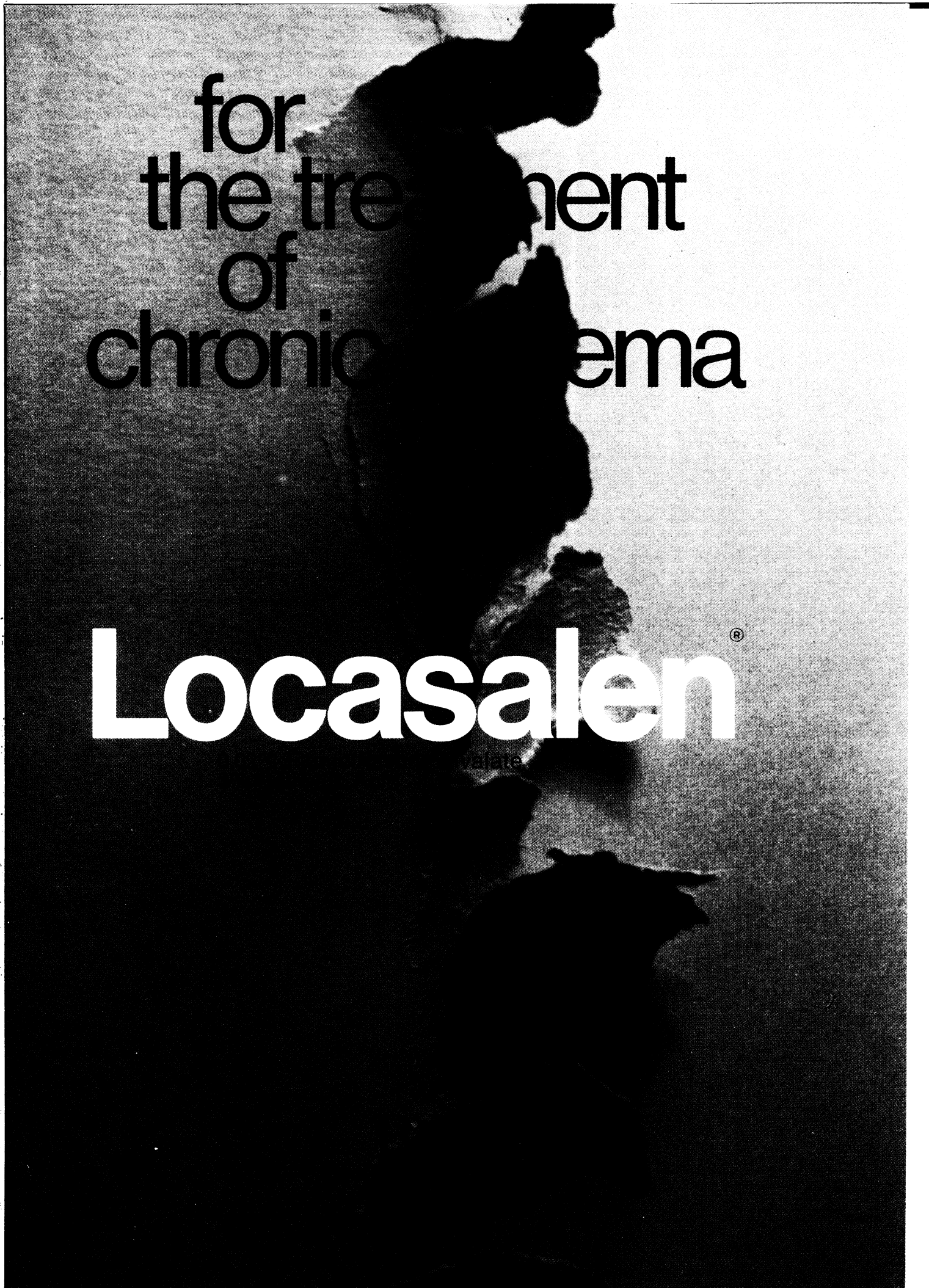
TY, M., Hematuria, Dec. p. 44

V

VALENTINE, A. S., What Is Family Practice? Maybe The E Book Can Tell You, Oct. p. 29
VAN WART, A. D., A Simplified Office Practice Record System, Feb. p. 103
VAYDA, E., GENT, M., PAISLEY, L., Social Class and Emergency Department Utilization, Feb. p. 117

W

WARNER, M. M., Conflicts in the Doctor/Patient Relationship: A Short Research Report, Sept. p. 67
WESTBURY, R., WONCA OKs ICHPPC, Feb. p. 49
WILKINS, G. E., Clinical Utilization of Thyroid Function Tests, Aug. p. 48
WOLAN, C. T. The Urological Examination in Family Practice, Dec. p. 30
WORKMAN, D. G., CUNNINGHAM, D. G., Effect of Psychotropic Drugs on Aggression In a Prison Setting, Nov. p. 64
WRIGHT, V. C., Evaluating Abnormal Pap Smears, Jan. p. 75
WYATT, J. K., Distal Urethral Stenosis In the Female, Dec. p. 47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21,681,000

Estimated population of Canada
by provinces at June 1, 1971
Source —
Statistics Canada, September 1, 1971.

those with edema

those with hypertension

Hygroton®

it's worth considering